Commonwealth of Massachusetts
Department of Public Safety

*This form must be faxed to the Department at **(617) 248-0813** within 24 hours of incident.*

AMUSEMENT INCIDENT REPORT

OWNER INFORMATION

Device Owner		Device State Tag #	
Owner Address		Ride Serial Number	
Owner City/ZIP		Month/Year Purchased	
Owner Contact		Purchased From:	
Owner Phone #		States operated in:	

INSURANCE / INSPECTION INFORMATION

Insurance Expiration Date:		Insurance Documentation Received Date	
Ride Inspector:		Inspector Commission #:	
Ride Inspection Dates:			
Type of Inspection / Inspection comments:			

MANUFACTURER INFORMATION

Ride Name		Type of ride (fixed or mobile)	
Manufacturer Name		Year of Manufacture	
Manufacturer Address		ASTM Standard applies? (Y/N)	
Manufacturer City/State		Number of rides made:	
USA Representative		Model Numbers / Names:	
Manufacturer Phone #			

WITNESS INFORMATION

WITNESSES	NAME OF WITNESSES OR PERSONS PRESENT	ADDRESS	PHONE

ACCIDENT / VICTIM INFORMATION

INJURED 1

Name of injured | Street | City/Town/State | Phone

Age: | Sex:

Ejected from Ride?

Yes ❑
No ❑

Injury Severity:

1. ❑ Killed
2. ❑ Serious Visible Injury
3. ❑ Minor Visible InjuryKilled
4. ❑ No visible injury but complaints of pain.

Restraint Used:

1. ❑ Seat belts
2. ❑ Mechanical Restraint
3. ❑ No Restraints
4. ❑ Other

Person Injured:

1. ❑ Operator
2. ❑ Passenger
3. ❑ Spectator
4. ❑ Other

Hospitalized? Yes ❑ No ❑

Nature of injury:

INJURED 2

Name of injured | Street | City/Town/State | Phone

Age: | Sex:

Ejected from Ride?

Yes ❑
No ❑

Injury Severity:

1. ❑ Killed
2. ❑ Serious Visible Injury
3. ❑ Minor Visible InjuryKilled
4. ❑ No visible injury but complaints of pain.

Restraint Used:

1. ❑ Seat belts
2. ❑ Mechanical Restraint
3. ❑ No Restraints
4. ❑ Other

Person Injured:

1. ❑ Operator
2. ❑ Passenger
3. ❑ Spectator
4. ❑ Other

Hospitalized? Yes ❑ No ❑

Nature of injury:

INJURED 3

Name of injured | Street | City/Town/State | Phone

Age: | Sex:

Ejected from Ride?

Yes ❑
No ❑

Injury Severity:

1. ❑ Killed
2. ❑ Serious Visible Injury
3. ❑ Minor Visible InjuryKilled
4. ❑ No visible injury but complaints of pain.

Restraint Used:

1. ❑ Seat belts
2. ❑ Mechanical Restraint
3. ❑ No Restraints
4. ❑ Other

Person Injured:

1. ❑ Operator
2. ❑ Passenger
3. ❑ Spectator
4. ❑ Other

Hospitalized? Yes ❑ No ❑

Nature of injury:

INCIDENT / ACCIDENT SUMMARY

Date of Incident:

:

Accident Classification (check boxes that apply)

Consumer Behavior (CB)	❑	Operator Behavior (OB)	❑
Mechanical Failure (MF)	❑	Design Limitations (DL)	❑
CB / MF	❑	OB / MF	❑
CB / OB	❑	OB /DL	❑

Name and signature_____

INCIDENT / ACCIDENT SUMMARY (SUPPLIMENTAL SHEET)

Witness or Victim Reporting:

Name and signature_____